STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 00 B. WING	05/12/2011

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AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN47150

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F0000	This visit was for a Recertification and State Licensure Survey. Survey Dates: May 9, 10, 11, 12, 2011 Facility number: 002657 Provider number: 155681 Aim number: 200308930 Survey team: Avona Connell, RN, TC May 9, 10, 12, 2011 Donna Groan, RN Dorothy Navetta, RN Gloria Reisert, MSW Census bed type: SNF: 44 SNF/NF: 36 Total: 80 Census payor type: Medicare: 29 Medicaid: 19 Other: 32 Total: 80 Sample: 16 Supplemental sample: 12 These deficiencies also reflect state findings cited in accordance with 410 IAC	F0000	May 6, 2011Autumn Woods Health Campus2911 Green Valley RoadNew Albany, Indiana 47150The submission of this Plan of Correction does not indicate an admission by Autumn Woods Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Autumn Woods. This facility recognizes it's obligation to provide legally and medically necessary services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compiance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance wit all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	16.2 Quality review completed 5-17-11 Cathy Emswiller RN			
F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			

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	A. Based on record review and interview, the facility failed to notify the physician when 1 of 1 resident with a brace in a sample of 16 residents failed to utilize the brace on a routine basis to prevent further injury. (Resident #12) B. Based on record review and interview, the facility failed to notify the responsible party when dental recommendations were made for 1 of 2 residents reviewed for oral care in a sample of 16 residents. (Resident #25) Finding includes: A1. Review of the clinical record for Resident #12 on 5/10/2011 at 11:07 a.m., indicated the resident was admitted from the hospital on 5/6/11 and had diagnoses which included, but were not limited to, left proximal humerus fracture, left supra condylar femur fracture and sickle cell anemia. Among the physician discharge instructions which accompanied the resident from the hospital, the orthopedic physician indicated the resident was to wear the caged knee brace to left lower extremity at all times. During an interview with the resident on 5/11/2011 at 8:50	F0157	1. Resident #12 order for brace discussed with physician and any new orders implemented. Resident #25's family was notified 5/11/11 on about Dental Consult.2. All dental progress notes, to include recommendations, written in the last 3 months will be reviewed and addressed for follow-up if indicated. Residents with orders for assistive devices were reviewed to insure appliances in place as ordered. Any issues identified were discussed with physician.3. Licensed staff inserviced by DHS or designee related to MD/Family Notification guidelines with emphasis on dental recommendations and assistive devices. 4. On going compliance will be maintained during daily CQI meetings where all new orders are reviewed to insure implementaion and notification made to MD and family. DHS or designee will review consultant recommendations as well. Audits will continue for 6 months and these results will be reviewed during QA meeting. If 100% compliance is not met consistently for 3 consecutive months, then audits will continue until this threshold is achieved.	06/11/2011

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	a.m., he indicated he did not like to wear his leg brace as it hurt and was uncomfortable. During an interview with physical therapist #1 on 5/11/2011 at 11:00 a.m., he indicated he was aware the resident was not wearing his knee brace despite encouragement and education but did not know if the resident's orthopedic surgeon was aware of this. He indicated he would notify nursing so that they may in turn, notify the orthopedic surgeon. Review of the nursing notes on 5/12/2011 at 9:40 a.m., failed to locate documentation of the surgeon having been notified the resident was not wearing his knee brace. During an interview with the Director of Health Services [DHS] at 9:45 a.m., she also was unable to locate documentation in the nursing notes nor on the 24 hour report of the orthopedic surgeon having been notified. LPN#1 at this time, also indicated she was aware the resident was not wearing his knee brace but not to the fact of the orthopedic surgeon having been notified. B1. Review of the clinical record for Resident #25 on 5/9/11 at 2:30 p.m., indicated the resident had diagnoses which included, but were not limited to,			

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	dementia with behavioral disturbance, depression, anxiety and agitation. Review of a 4/18/2011 dental visit indicated the following: "As written 4/28/2010, pt [patient] needs to see dentist who placed implants/denture retainer for replacement (retainer in denture] or removal. We believe he was in [name of town]." Documentation was lacking by nursing of the responsible party having been notified of the recommendation having been re-written again on 4/18/2011. During an interview with LPN #2 on 5/10/2011 at 2:37 p.m., he indicated it was nursing's responsibility to contact the family when a consultant [i.e. dentist] made a recommendation for a referral to an outside source for treatment and then make that referral. On 5/11/2011 at 12:05 p.m., the Administrator presented a copy of the facility's current policy on "Physician Notification of Diagnostic Testing and Change in Condition". Review of this policy at this time included, but was not limited to, "Purpose: To ensure the resident's physician is aware of ...change in condition in a timely manner to evaluate condition for need of provision			

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	of appropriate interventions for care. Procedure:...3. All other test results or order requests (non-critical) may be faxed to the physician office during office hours...5. During non-office hour times the nurse should notify the physician by phone of...the need for physician intervention...10. Attempts to notify the physician and their response should be documented in the resident record...." 3.1-5(a)(3)			
F0241 SS=D	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview and record review, the facility failed to ensure	F0241	1. Resident #71 was reassessed upon notification of surveyor to insure no further issues with	06/11/2011

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	residents were provided visual privacy while being examined for 1 of 2 sampled residents observed in the dining room. (Resident #71) and 2 of 5 residents in the group meeting who complained of physician exams in public (Resident #101 and #104). Findings include: On 5/9/11 at 5:25 p.m., in the Health Care dining room, Resident #71 was observed scratching her stomach. The Director of Nursing went over to the resident and began looking at the residents stomach. The DON indicated it was dry skin and someone would put cream on it. The DON failed to take the resident from the dining area into a private area to be examined. There were two other residents seated at the table at this time. On 5/10/11 at 9:35 a.m., during the Group Meeting here, residents #101 and #104 indicated their doctor would examine them in the dining room. When queried, they indicated the doctor listened to their heart and chests with other residents present. On 5/12/11 at 3:05 p.m., the DON provided a copy of the Bill of Resident Rights dated 2004 which included, but was not limited to: "Privacy and		itching. Dignity issues addressed with Physicians seeing residents at this campus.2. Resident Council meeting will be held to discuss Resident Rights with emphasis on dignity.3. All staff inserviced by Social Services or designee related to Resident Rights with emphasis on Dignity issues. Attending Physicians will be alerted to resident concerns expressed about examinations in public areas.4. Compliance will be monitored through discussion at Resident Council Meetings for the next three months. Any concerns will be reported to the Executive Director who will intervene.	

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	Confidentiality: 17. You have the right to personal privacy and confidentiality of your personal and clinical records. Personal privacy includes privacy in accommodations, medical treatment, written and telephone communication, personal care... 3.1-3(t)			
F0250 SS=D	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview the facility failed to ensure medically related social services were provided for 2 of 3 resident's reviewed for a psychiatric evaluation in a sample of 16. (Resident # 32, #73) Findings include: 1. The clinical record for Resident #32 was reviewed on 5/10/11 at 9 a.m. The resident diagnoses included but were not limited to depression. The resident was admitted to the facility on 4/12/11. A Physician Order dated 4/15/11 indicated "Dr. [named] to follow" Review of the consult section of the clinical record lacked any notes from Dr. [named]. On 5/10/11 at 11:25 a.m. the Social Service Director indicated she makes the appointments for the psych	F0250	1. Residents #32 & #73 have received a psychiatric evaluation. 2. Referrals for psychiatry for the last 30 days will be reviewed and referrals will be communicated to the psychiatrist and an evaluation scheduled as indicated.3. The Social Worker was re-inserviced on the policy and procedure "Referrals." Nurses were re-educated regarding notification of Social Services in the event a referral is received. The Interdisciplinary team was re-inserviced on the process of reviewing all physician orders in the daily CQI meeting which would include psych referrals and Social Services will now particpate in this daily review to ensure communication.4. Audits will be conducted through the daily CQI process. Physician	06/11/2011

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	evaluations. She indicated she "missed it." 2. The clinical record for Resident #73 was reviewed on 5/11/11 at 8 a.m. The resident diagnoses included, but were not limited to: chronic obstructive pulmonary disease. The resident was admitted to the facility on 4/12/11. A Physician Order dated 4/19/11 indicated "Consult Dr. [named] Group" Review of the consult section of the clinical record lacked any notes from Dr. [named]. On 5/11/11 at 9:35 a.m. in interview with the Social Services Director she indicated "It's my fault. It's another one." On 5/11/11 at 12:05 p.m., the Administrator provided the Policy and Procedure "Referrals" which included, but was not limited to: "Policy Statement Social services personnel are responsible for coordinating resident referrals to outside agencies. Policy Interpretation and Implementation: 1. Social services shall coordinate all resident referrals." 3.1-34(a)		orders are reviewed and follow through on these orders is checked during this process. Results will be reviewed in monthly QA to ensure CQI is effective with 100% compliance of follow through on referrals.	

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F0280 SS=D	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review and interview, the facility failed to revise the care plan for 1 of 2 residents reviewed for oral care in a sample of 16 residents when the dentist made recommendations for better oral hygiene to prevent further tooth and gum decay. (Resident #51) Finding includes: Review of the clinical record for Resident #51 on 5/11/2011 at 5:35 a.m., indicated the resident had diagnoses which included, but were not limited to, dementia of Alzheimer type with mood disturbance, muscle weakness and depression.	F0280	1. Careplan for Resident #51 was reviewed and updated to reflect current status.2. Careplans for current residents were reviewed and updated as necessary by the Interdisciplinary Team to insure accuracy and reflect current status. 3. Interdisciplinary Care Plan Team inserviced by Clinical Support Staff related to care plan revision.4. Ongoing monitoring will be achieved by audits during morning CQI meeting that will insure careplans are updated to reflect curent status of resident. Monitoring will also take place during quarterly careplan meetings and during Home Office Peer Review.	06/11/2011

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	During an interview with the resident's responsible party on 5/9/2011 at 6:00 p.m., she indicated she was very upset after recent dental appointments she had taken the resident to as the dentist had found several problems with her teeth, including the teeth now soft due to lack of brushing. She indicated the resident had "perfect" teeth when she first brought the resident to the facility, but that the dentist had indicated to her that the teeth were now soft, there was a build-up of plaque and the resident now had several cavities. A 10/4/2010 annual dental visit note indicated the following: "Pt [patient] has natural teeth, tooth #11 is broken and appears asymptomatic at this time, pt would benefit from prophy [teeth cleaning] - pt not able to agree or disagree to prophy." Review of a 12/3/2010 dental visit note indicated: "the resident had been seen a total of 3 times and that after each visit, the resident's teeth looked as if they had been barely brushed or not at all. She came in with heavy plaque on her teeth and apparently it has been there for awhile, and with no change between her visits to the office. [name of dentist], with his dental hygienist, and their degree in the dental field, feel that [resident] needs			

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	better care of her teeth and gums to prevent all the decay that was apparent today. This is very important to [resident] and for the benefit of her health also. The teeth and gums can play a very big role in her health." On 6/3/2009, a care plan on "ADL [activities of daily living] Deficit" was written which indicated the resident needed assistance or was dependent in personal hygiene. The interventions included, but were not limited to, "Assist with personal hygiene as needed including Oral/dental care." No other review dates were listed. When interviewed on 5/12/2011 at 10:00 a.m., the Regional Corporate Nurse and the Director of Health Services [DHS] indicated they had discussed the resident's poor oral care and that in February 2011, the interdisciplinary team had decided to add it to the treatment records for the nurse to check off every day the resident's teeth had been properly brushed. The Regional Corporate Nurse indicated she felt the care plan did not need to list any further interventions since they added this to the treatment records. During an interview with RN #1 on 5/12/2011 at 10:20 a.m., she indicated staff could update the care plans anytime a			

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	problem arose and did not have to wait until the next care plan meeting. She also indicated the care plans were reviewed every care plan meeting and additional interventions more specific to care of the resident's teeth should have been added after the dentist's visit. RN #1 presented at this time, a copy of an interdisciplinary care plan meeting summary she indicated was held in February 2011 which included, but was not limited to the following items: "Reports dentist reported teeth have not been brushed routinely which has caused decayed (sic). Staff to brush [resident's] teeth [after] meals and hs [at night] and place on TAR [Treatment Administration Record] for staff to sign was completed." The RN indicated she obtained an order this day 5/12/2011 from the physician for the resident to have teeth brushed after each meal and at night and had also wrote on the TAR starting in February 2011 where the staff had to look at the resident's mouth and sign off the care had been provided. Review of the TAR for February, March and April 2011 noted a few holes where the treatment had not been checked after supper and at bedtime with the breakfast and lunch treatment missing an initial of the nurse having checked the teeth to			

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	verify care had been provided on 2/20, 2/21, 2/23, 2/24, 2/27. 2/28 and all of April. During an interview with LPN #3 and CNA #3 on 5/11/2011 at 8:25 a.m., they indicated they were aware that the last time the resident went out to the dentist, the dentist did write a note indicating the resident was lacking good oral care and that the resident needed better oral care and had cavities. She indicated that since the responsible party had bought an electric toothbrush, it was easier to do the resident's teeth as she won't sit still very long and did not understand how to rinse and spit. She also indicated nursing had now started documenting if the resident refused to allow staff to brush. Review of the interdisciplinary care plan for "Behaviors" implemented on 1/10 with review dates of 3/10 and 5/2/2011, failed to indicated the resident was resistive to care, especially having her teeth brushed. On 5/12/2011 at 8:50 a.m., the DHS presented a copy of the facility's current policy and procedure on "Interdisciplinary Team Care Plan Guideline". Review of this policy at this time, included, but was not limited to: "Purpose: To ensure appropriateness of services and			

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	communication that will meet the resident's needs, severity/stability of conditions, impairment, disability in accordance with state and federal guidelines. Procedure:...d. each discipline shall be responsible for establishing a plan of care for acute problems as they occur...f. The comprehensive care plan should be revised to reflect change in condition updates with each MDS [Minimum Data Set] assessment. ..h. The care plan should be reviewed and revised as needed with each MDS assessment...j. New problem areas should be printed and added to the existing care plans..." 3.1-35(d)(1) 3.1-35(d)(2)(A) 3.1-35(d)(2)(B)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview the facility failed to ensure physician orders were followed for a psychiatric evaluation for 2 of 3 residents reviewed with orders for a psych eval in a sample of 16. (Resident #32, #73) Findings include: 1. The clinical record for Resident #32	F0282	1. Residents #32 & #73 have received a psychiatric evaluation. 2. Referrals for psychiatry for the last 30 days will be reviewed and referrals will be communicated to the psychiatrist and an evaluation scheduled as indicated.3. The Social Worker was re-inserviced on the policy and procedure "Referrals." Nurses were re-educated regarding notification of Social Services in the event a referral is	06/11/2011

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	was reviewed on 5/10/11 at 9 a.m. The resident diagnoses included but were not limited to depression. The resident was admitted to the facility on 4/12/11. A Physician Order dated 4/15/11 indicated "Dr. [named] to follow" On 5/10/11 at 11:25 a.m. the Social Service Director indicated she makes the appointments for the psych evaluations. She indicated she "missed it." 2. The clinical record for Resident #73 was reviewed on 5/11/11 at 8 a.m. The resident diagnoses included, but were not limited to: chronic obstructive pulmonary disease. The resident was admitted to the facility on 4/12/11. A Physician Order dated 4/19/11 indicated "Consult Dr. [named] Group" On 5/11/11 at 9:35 a.m. in interview with the Social Services Director she indicated "It's my fault. It's another one." 3.1-35(g)(2)		received. The Interdisciplinary team was re-inserviced on the process of reviewing all physician orders in the daily CQI meeting which would include psych referrals and Social Services will now particpate in this daily review to ensure communication.4. Audits will be conducted through the daily CQI process. Physician orders are reviewed and follow through on these orders is checked during this process. Results will be reviewed in monthly QA to ensure CQI is effective with 100% compliance of follow through on referrals.	
F0312 SS=D	A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on record review, observation and interview, the facility failed ensure 1 of 2 residents reviewed for oral care in a	F0312	1. Resident #51 has schedule for oral care implemented based on dentist recommendations.2. Residents who require assistance	06/11/2011

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	sample of 16 residents had received proper oral hygiene to prevent tooth and gum decay. (Resident #25) Finding includes: Review of the clinical record for Resident #51 on 5/11/2011 at 5:35 a.m., indicated the resident had diagnoses which included, but were not limited to, dementia of Alzheimer type with mood disturbance, muscle weakness and depression. During an interview with the resident's responsible party on 5/9/2011 at 6:00 p.m., she indicated she was very upset after recent dental appointments she had taken the resident to as the dentist had found several problems with her teeth, including the teeth now soft due to lack of brushing. She indicated the resident had "perfect" teeth when she first brought the resident to the facility, but that the dentist had indicated to her that the teeth were now soft, there was a build-up of plaque and the resident now had several cavities. A 10/4/2010 annual dental visit note indicated the following: "Pt [patient] has natural teeth, tooth #11 is broken and appears asymptomatic at this time, pt would benefit from prophy [teeth cleaning] - pt not able to agree or disagree		with oral care were assessed to ensure provided per protocol.3. Nurses and CNAs will be re-inserviced by the DHS or designee regarding the expectations for resident oral care.4. Audits for oral care will be conducted during rounding 5 times per week times one month, 3 times per week times 2 months, then 1 time per week for 3 months. Results will be reviewed during QA meeting. If 100% compliance is not met for 3 consecutive months, then weekly audits will continue until this threshold is met.	

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	to prophy." Review of a 12/3/2010 dental visit note indicated: "the resident had been seen a total of 3 times and that after each visit, the resident's teeth looked as if they had been barely brushed or not at all. She came in with heavy plaque on her teeth and apparently it has been there for awhile, and with no change between her visits to the office. [name of dentist], with his dental hygienist, and their degree in the dental field, feel that [resident] needs better care of her teeth and gums to prevent all the decay that was apparent today. This is very important to [resident] and for the benefit of her health also. The teeth and gums can play a very big role in her health." During random observations of the resident on 5/9/2011 between 11:30 a.m. and 5:55 p.m., and on 5/11/2011 between 8:10 a.m. and 12:20 p.m., when the resident smiled or responded to questions, observations of her teeth indicated teeth to be dull and stained with some plaque observed. During an interview with CNAs [certified nursing assistants] #1 and #2 on 5/11/2011 at 6:00 a.m., they indicated the resident was usually cooperative with oral care and was willing to stand there and let			

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	one brush her teeth and then rinse and spit. They indicated the resident did have moods where she wouldn't let staff do anything for her. During an interview with LPN #3 and CNA #3 on 5/11/2011 at 8:25 a.m., they indicated they were aware that the last time the resident went out to the dentist, the dentist did write a note indicating the resident was lacking good oral care and that the resident needed better oral care and had cavities. She indicated that since the responsible party had bought an electric toothbrush, it was easier to do the resident's teeth as she won't sit still very long and did not understand how to rinse and spit. She also indicated nursing had now started documenting if the resident refused to allow staff to brush. Review of the nursing notes between 10/1/2010 and 5/11/2011 noted only 1 entry in which the resident was resistive to having her teeth brushed by clamping her teeth shut and refusing to sit down. 3.1-38(b)(1)			
F0323 SS=E	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A. Based on record review, observation	F0323	1. Floor mat alarm was checked	06/11/2011

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	and interview, the facility failed to ensure a floor mat alarm identified as a safety intervention after a fall was functional to alert staff when rising for 1 of 3 residents reviewed for falls in a sample of 16 residents. (Resident #41) B. Based on observation, interview and record review, the facility failed to ensure hazardous materials were secured properly behind locked doors of 2 of 3 storage rooms on 1 of 3 units (Legacy Lane). This deficient practice had the potential to affect 23 of 23 residents who currently reside on the dementia unit. C. Based on observation, interview and record review the facility failed to ensure cleaning supplies, hand sanitizers, kitchen knives and resident care equipment were stored securely on 2 of 3 resident occupied halls. (Health Care and Transitional Care) Finding includes: A . Review of the clinical record for Resident #41 on 5/9/2011 at 1:20 p.m., indicated the resident had been admitted from another facility on 4/20/2011 and had diagnoses which included, but were not limited to, abnormality of gait, thrombocytopenia [a blood disorder], muscle weakness and degenerative joint		and was functioning on date identified by surveyors. All hazardous materials, cleaning supplies, hand sanitizers, kitchen knives and resident care equipment were removed and/or secured in locked areas.2. All units and storage areas checked for hazardous items and removed/stored as required in locked areas. Residents with alarms were checked to ensure that alarms in place and functioning.3. All staff inserviced on by DHS or designee on Storage of Drugs and Biologicals. Nursing staff inservice by DHS or designee related to alarms with emphasis on fall prevention.4. Monitoring for ongoing compliance will be achieved during daily rounds times 3 months by Charge Nurses, and/or Director of Health Services who will observe for hazardous materials not stored properly. Random rounds for observations will occur on a weekly basis, thereafter. Any staff identified not following protocol will be counseled and or reeducated as necessary. Nursing staff will also be responsible to ensure that alarms are in place and functioning on a daily basis. Nonfunctional equipment will be replaced. Monitoring will also occur by Home Office staff during Peer Review.	

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disease.

A 4/17/2011 hospital admission note indicated the resident had a fall at home and was brought to the emergency room for evaluation and treatment. He was subsequently transferred to another nursing facility on 4/19/2011 where he had a fall as he had a tendency to lean to the right.

On 4/20/2011, the resident was admitted to the current facility with physician orders for a wanderguard, bed and chair alarms, and to be ambulating with assistance. The admission nursing evaluation indicated was dependent on one for transfers and dependent on one to two for ambulation.

Review of the nursing notes between 4/20 and 5/3/2011 indicated the resident was up and down all night frequently and refused to use his walker. On 5/3/2011, nursing notified the physician of the resident becoming agitated by the sound of the bed alarm with frequent removal of the alarm. The physician subsequently gave an order to discontinue the bed and chair alarms on 5/3/2011 at 8:00 a.m..

At 11:45 p.m. on 5/3/2011, the resident was found sitting in the bathroom on the commode. An abrasion on the right side

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	of his forehead was observed. The physician was notified who gave new orders for neurochecks and treatment of the abrasion. On 5/8/2011 at 11:45 p.m., the resident was found standing at the foot of his bed with dried blood observed on his body. A skin tear was observed to his right forearm. At 11:55 p.m., the physician gave new orders for the resident's bed to be against the wall and to place a floor mat alarm. On 5/9/2011 during an random passing observation at 2:10 p.m., Resident #41 was observed standing up on his mat removing his pants. Upon interview with LPN #6 and CNA #4 on 5/9/2011 at 2:15 p.m. as to whether the resident was supposed to have an alarm on to notify the staff when standing, LPN #6 indicated the resident's alarms had been discontinued. When CNA #4 had inquired if the floor mat alarm had actually been discontinued as she indicated she would then remove it, the LPN indicated that after thinking about it, she remembered the floor mat alarm had been added back as a new intervention after the resident's fall last night. The LPN and CNA were then informed of the observation of the resident standing up on the mat to remove his pants.			

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While accompanying CNA #4 to the resident's room, it was observed that the alarm cord had been unplug from the alarm box. The CNA demonstrated by standing on the floor alarm that it was not presently working because it had been unplugged. After plugging it in, she then demonstrated that it was now working. No other alarms were observed not to be working when checked with the CNA after leaving the resident's room.

B. During a random observation on Legacy Lane on 5/9/2011 at 5:05 p.m., the following was observed in the storage closet across from the unit's main dining room/lounge:
a. 1 - 12 ounce can of Lamaur Vita/e ultra hold hair spray with a warning label of: keep out of reach of children, keep away of radiator, stove or other source of ignition, no direct sunlight.

b. 1 - 20 ounce bottle of Personal Care Cocoa Butter Skin Care lotion with a warning label of: keep out of reach of children and external use only.

c. 1 -22.5 ounce bottle of Suave Lotion with a warring label of: for external use only.

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	d. 1 - 24.5 ounce bottle of Walgreens Complete Moisture Dry Skin Lotion with a warning label of: for external use only. e. 1 - 10.64 ounce bottle of Coppertone Sunblock lotion 45 SPF with a warring label of: keep out of reach of children, avoid ingestion and contact with eyes, external use only. f. 1 - 32 ounce bottle of Medline Remedy with Oliveamine Skin Repair Cream with a warning label of: external use only, keep out of reach of children. g. 1 small plastic bin with 2 nail clippers, 1 cuticle scissors, and 1 fluid ounce of instant cuticle remove with a warning label of: harmful if swallowed, keep out of reach of children. h. 1 suitcase tote full of bottles of nail polish and an 8 ounce bottle of Swan nail polish remover strengthening formula with a warning label of: harmful if swallowed, keep out of reach of children, external use only. 15 of 23 residents identified during the initial tour with LPN #6 on 5/9/2011 at 11:30 a.m., as being confused were observed in the unit's main dining room/lounge with 2 also identified as confused residents in front of the closet			

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	door. During an interview with LPN #6 at this time indicated she was not sure when or who was the last person in the closet. She also indicated the door was on a code system and was supposed to shut automatically. CNA #6 at this time, also indicated the door was supposed to close automatically but might have been a little tight and staff knew they had to physically push it shut. During an interview with Activity Assistant #1 on 5/12/2011 at 9:42 a.m., she indicated the door to the unit's storage room was supposed to close and lock automatically but that staff also knew that it was to be pushed shut to ensure it locked. C. 1. On 5/10/11 at 10:30 a.m. on the Transitional Care Unit, in the pantry area the following was observed in unlocked drawers and cabinets: 3 - 15 oz. (ounce) bottles of liquid hand sanitizer were in the cabinet next to the refrigerator, a 6 inch butcher knife was in the first drawer under the microwave. In interview with the Administrator, at this time, she indicated this "was not our standard." At this time, there was one confused resident on the 500 Hall as identified by staff. During the initial tour on 5/9/11 between			

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	C. 2. On 5/10/11 at 10 40 a.m., on the Health Care Unit, across from the nurse station, were unlocked cabinets in which the following were observed: 4 - 15 oz. bottles of liquid hand sanitizer, 1 can of air wick spray in a drawer and a spray bottle of Virex. In interview with the DON, at this time, these items were not to be in the drawers and cabinets. At this time, there were eight residents identified as confused on the Health Care Unit and one confused resident on the Transitional Unit as identified by staff during the initial tour on 5/9/11 between 11:15 a.m. and noon. The Director of Nursing provided the undated policy and procedure for "Storage of Hazardous Chemicals". The policy included, but was not limited to: "Purpose: To ensure the safety of residents related to exposure to hazardous chemicals...2. Hazardous chemicals should be stored in a locked area when not in use." C. 3. On 05/09/11 at 5:15 p.m., the door to the linen closet was unlocked and unattended on the Transitional Care Unit. The closet also contained the following items:			

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1. Five and 1/2 bottles of instant Hand Sanitizer, fifteen ounces each.

2. Eleven disposable razors.,

3. Eighteen Soothe and Cool Herbal Conditioning Shampoo and Body Wash. Eight ounces each.

4. Fourteen four ounce tubes of Emendy Nutrashield labeled for external use only.

5. Eighteen tubes of McKesson Fluoride Tooth Paste.

In interview with Licensed Practical Nurse #4, at 5:23 p.m., on 05/09/10, when asked if the door should be locked she indicated "does not think it has to be locked" "don't think it has ever been locked."

At 8:50 a.m. on 05/10/11, the Administrator provided the Material Safety Data Sheets for the above products:

A. Soothe & Cool Herbal Conditioning Shampoo/Body Wash:
Emergency and First Aid Procedures:
Eye contact: irrigate eye with warm water for ten minutes minimum.
If swallowed give two glasses of water.

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	Do not induce vomiting. Seek medical attention immediately. B. Remedy, Nutrashield Cream : Emergency and First Aid Procedures: Eye contact: Flush with water, get medical attention if irritancy persists. Ingestion: If large quantities are ingested, get medical attention. C. McKesson Fluoride Tooth Paste: First Aid Measures: Ingestion of large quantities may cause irritation to the gastrointestinal system. D. Instant Hand Sanitizer: First Aid Measures: Eyes: Flush with clear water for 15 minutes. Swallowed: If patient is conscious and alert, dilute by drinking large quantities of water. Allow vomiting to occur then get medical attention. E. On 05/12/11 at 3:110 p.m. the Director of Nursing provided the Material Safety Data Sheet for VIrex Tb Ready-To-Use Disinfectant Cleaner. First Aid Measures Eye contact: Hold eye open and rinse slowly and gently with water for 15-20 minutes. Remove contact lenses, if present, after the first 5 minutes, then			

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	continue rinsing eyes. If irritation persists, get medical attention. Skin: Flush immediately with plenty of water. If irritation persists, get medical attention. Ingestion: Immediately drink one cupful of water or milk. Get medical attention. 3.1-45(a)(1)			
F0363 SS=E	Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. Based on observation, interview and record review the facility failed to follow recipes for pureed food for 1 of 1 pureed foods observed being prepared. This deficient practice had the potential to affect 7 residents receiving pureed diets. (Residents #30, 48, 53, 72, 76, 80, 62) Findings include: On 5/11/11 between 6:30 a.m. and 7:15 a.m., Cook #1 was observed to puree the following recipe: Egg Scrambled w/Bacon Pureed dated 8/30/2010. The Cook indicated she was going to puree for 10	F0363	1. Residents #30, 48, 53, 72, 76, 80, and 62 all received eggs that included pureed bacon as the Dietary Manager addressed the concerns with the bacon prior to serving the pureed eggs.2. No other residents had the potential to be affected.3. Cook #1 and all other Cooks were re-inserviced by the Director of Food Services on the importance of following recipes for pureed foods. The DFS or designee will observe each cook preparing a pureed food to ensure understanding and check off this skill.4. Audits will be conducted by the DFS or designee to ensure following recipes to include 5	06/11/2011

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	servings. She also indicated the bacon would not puree well. The recipe included, but was not limited to the following: Ultra Pasteurized Liquid Egg 2 1/2 Cup, 2% White Milk 1/2 Cup 2 Tablespoon, Water 1 3/4 cup 2 Tablespoon, Grade A Unsalted Butter Print 2 2/3 Tablespoon, Sliced Bacon 10 1 Slice, and Puree Appeal 1/2 Cup 2 Tablespoon. Cook #1 failed to include the butter and bacon during the processing. On 5/11/11 at 8:10 a.m., breakfast was observed being served to the residents on the secured unit. At this time, brown specks were observed in the pureed eggs being served. On 5/11/11 at 10:30 a.m., in interview with the Dietary Manager, he indicated he added the bacon before the pureed eggs were served. At this time, he provided a list of residents currently receiving pureed foods which included residents #30, 48, 53, 72, 76, 80, and 62. On 5/12/11 at 7:50 a.m., the facility provided the Job Description for a "Cook" which included, but was not limited to "The Cook is primarily responsible for food preparation for the Health Campus." The Job Specific Orientation Checklist received, at this time, indicated Cook #1		times per week for 1 month, 3 times per week for 2 months, and 1 time per week for 3 months. Results will be reviewed in monthly QA and if 100% compliance is not reached for 3 consecutive months then 1 time per week audits will continue until this threshold is met.	

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	on 7/12/06 was trained on Dietary Policies & Procedures, Menu's & Production which included, but was not limited to: Prep & Yield and Standardized Recipes - How to Read." On 5/12/11 at 10:35 a.m., the Assistant Dietary Manager provided a list of residents currently receiving pureed foods which included residents #30, 48, 53, 72, 76, 80, and 62. 3.1-21(a)(1) 3.1-21(a)(3)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview the facility failed to ensure 1 of 5 dietary employees hands were washed. This deficient practice had the potential to effect 74 out of 80 residents. Findings include: On 5/11/11 between 6:30 a.m. and 7:15 a.m. cook #1 was observed taking the fry pan after cooking scrambled eggs to the	F0371	1. Cook #1 was re-educated by the DFS on the campus Handwashing policy and procedure.2. All residents who are not NPO have the potential to be affected and therefore all Cooks will be re-educated by the DFS on the campus Handwashing policy and procedure and a skill check off will be conducted.3. Additional Handwashing signs were hung in the kitchen as reminders to wash hands.4. Audits of handwashing will be conducted 5 times per	06/11/2011

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	dirty sink area. She then took hold of the spray nozzle, rinsed the pan, went to the robo coupe and proceeded to puree the scrambled eggs. Cook #1 then went to the preparation sink to get water for the puree recipe, turned the sink on and off and returned to the mixing of ingredients. She failed to remove the gloves and/or wash her hands during the process. On 5/12/11 at 1:25 p.m., in interview with the assistant dietary manager, he indicated on 5/11/11, six residents were on nothing by mouth (NPO) diets. 3.1-21(i)(3)		week for 1 month, 3 times per week for 2 months, and 1 time per week for 3 months. Results will be reviewed in monthly QA and if 100% compliance is not reached for 3 consecutive months, then 1 time per week audits will continue until this threshold is met.	
F0411 SS=D	The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. Based on record review, observation and interview, the facility failed to follow-up on a dental recommendation and obtain a dental consult with the resident's previous	F0411	1. Resident #25 has now been assessed by Dentist per dental recommendation.2. All dental progress notes, to include recommendations, written in the last 3 months will be reviewed	06/11/2011

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	dentist for 1 of 2 residents reviewed for dental issues in a sample of 16 residents. (Resident #51) Finding includes: Review of the clinical record for Resident #25 on 5/9/11 at 2:30 p.m., indicated the resident had diagnoses which included, but were not limited to, dementia with behavioral disturbance, depression, anxiety and agitation. During random observations of the resident on 5/9/2011 between 11:30 a.m. and 5:55 p.m., and on 5/11/2011 between 8:10 a.m. and 12:20 p.m., when the resident smiled or responded to questions, observations of her teeth indicated teeth to be dull and stained with some plaque observed. Review of a 4/18/2011 dental visit indicated the following: "As written 4/28/2010, pt [patient] needs to see dentist who placed implants/denture retainer for replacement (retainer in denture] or removal. We believe he was in [name of town]." Documentation was lacking by nursing of the referral to the previous dentist out of town or to a local dentist having been made.		and addressed for follow-up if indicated.3. All nurses will be re-inserviced by the DHS or designee on the importance follow-up on dental recommendations. In addition, the Social Worker will be in-serviced by the ED or designee on the new system of her follow-up on dental referrals. The contracted dental group will exit after each campus visit with the Social Worker or designee, note any recommendations on their resident roster, and the Social Worker will follow-up to ensure referrals have been initiated.4. All dental recommendations will be audited by the DHS or designee for 3 months. A minimum of 5 dental recommendations per month will be audited for 3 additional months. If 100% compliance is not reached for 3 consecutive months, then a minimum of 5 audits will continue per month until this threshold is met.	

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	During an interview with LPN #2 on 5/10/2011 at 2:37 p.m., he indicated it was nursing's responsibility to contact the family when a consultant [i.e. dentist] made a recommendation for a referral to an outside source for treatment and then make that referral. During an interview with LPN #5 on 5/9/2011 at 4:15 p.m., she indicated the resident had a type of implants the dentures would be able to snap onto but that upon questioning the resident's family, no one was sure who the previous dentist was and where the resident's dentures were at. She indicated that the facility had at one time been working on the previous recommendation about an outside dentist, but that nothing had ever come of it. 3.1-24(a)(1) 3.1-24(a)(3) 3.1-24(b)			

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F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview the facility failed to ensure the clinical records were complete and accurately documented for 1 of 16 records reviewed. (Resident #91) Findings include: The clinical record for Resident #91 was reviewed on 5/11/11 at 10:00 a.m. The resident's diagnoses included, but were not limited to: chronic obstructive pulmonary disease, obstructive sleep apnea, status post ventilatory support, status post respiratory failure, immobility syndrome, paroxysmal atrial fibrillation and congestive heart failure. Review of the Physician's Orders for March 2011 and April 2011 included, but was not limited to: "oxygen saturation (O2) levels every shift." Review of the treatment administration	F0514	1. Resident #51 orders were reviewed to determine if any other documentation issues present. Any corrections that could be made were corrected based on information in record.2. Current resident MARs/TARs reviewed to determine if holes were present in documentation.3. Nurses inserviced on by DHS or designee related to ensuring that treatments ordered and implemented are documented timely and thoroughly.4. Medical Records or DHS will review MARS/TARS 5 times per week for a minimum of 3 months to ensure complete documentation is taking place. Once 100% compliance is achieved, this audit will be be weekly. Nurses not complying with policy will be counseled and/or reeducated as necessary. Quality Assurance Committee will be responible for requiring corrective action plan for any pattern of noncompliance.	06/11/2011

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	records (TAR) from 2/6/11 to 3/29/11 at 10:05 lacked documentation indicating that O2 levels were checked every shift. Documentation was lacking for 34 of 159 shifts. On 5/12/11 at 10:10 a.m., in interview with the Regional Nurse Consultant, she indicated the expectation is that documentation was to be on the TAR or in the nurse's notes. Documentation was lacking on the TAR and in the nurse's notes. 3.1-50(a)(1) 3.1-50(a)(2)			
F9999	STATE RULE: 3.1-14 PERSONNEL A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test , using the Mantoux method (5 TU PPD), administered by persons having documentation of training from a department- approved course of instruction in intradermal tuberculin skin testing, reading, and recording unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom	F9999	1. The Activities Director .....given ppd or no longer employed?2. Records of employee hired within the last 12 months will be reviewed to ensure compliance with the requirement for tuberculin skin testing.3. system change? who monitors? inservice who? 4. Audits of all new employee records will be conducted by the ED or designee for 6 months. Results will be reviewed in montly QA and if 100% compliance is not reached for 3 consecutive months, then audits of all new employee files will continue until this threshold is met.	06/11/2011

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	administered. The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following: At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. This State Rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure employees were screened for tuberculosis at the time of employment or within one month prior to employment. This deficient practice affected 1 of 7 employee files reviewed. (Activity Director) Findings include: During the review of the employee files			

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	on 05/12/11 between 7:55 a.m. and 09:30 a.m., the following was identified: The Activities Director with a start date of 12/29/10, lacked documentation of screening for tuberculosis,s at the time of employment. The last tuberculin skin test was administered on 09/29/10., at the previous place of employment. In interview with the Administrator, on 05/12/11 at 9:30 a.m., she indicated the tuberculin skin test was not given at the time of hire on 12/29/10. 3.1-14(t) 3.1-14(t)(1)			